

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN3307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/07/2011
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COLLEGEDALE			STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 658, 9210 APISON PIKE COLLEGEDALE, TN 37315		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments During investigation of C/O #25041, #25060, #25080, #25195, #25377, #25417, #27224, #27361 and #28250, conducted June 27-29, 2011, at Life Care Center of Collegedale, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

FO8N11

TITLE

Administrator

(X6) DATE

7/18/11

If continuation sheet 1 of 1

JUL 19 2011